Implementing Whiteboard Use To Eliminate Unintended Retained Foreign Objects
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THEORETICAL FRAMEWORK
- Lewin’s Change Management Theory guides theoretical framework
- Unfreezing, Change, and Refreezing stages
  - Decrease resisting forces
  - Increase driving forces
  - Overcome resistance to change

PROJECT PURPOSE
- To implement Whiteboard (WB) use
- To increase the accuracy of the surgical count
- To eliminate Unintended Retained Foreign Objects (URFOs)
- To increase patient safety and improve patient outcomes

PROJECT DESIGN
- Setting
  - 5 operating room suites
  - For-profit Ambulatory Surgical Center (ASC)
- Task force included:
  - Director of Nursing
  - Quality Improvement Director
  - Interdisciplinary operating room (OR) staff
- Best Evidence located, assessed, and critically analyzed
- GAP analysis conducted

PLANNING
- GAP analysis presented to the medical executive committee
- An evidence-based plan using whiteboard approved
- Whiteboards increase the culture of safety in the OR

IMPLEMENTATION
- Project management team formed
- New surgical count policy developed and approved
- Surgical counts now recorded as correct or incorrect
- Staff champions identified and trained
- Champions decrease resistance and improve compliance
- Education materials and standardized template developed
- Interdisciplinary team members participate in the count

RESULTS
- OR STAFF POST-USE FEEDBACK
- OBSERVATIONAL DATA
  - Name & Allergies: 81%
  - Initial count: 81%
  - Initial count before the cut: 69%
  - Count changed for new supplies or medications: 81%
  - Kept current and used as reference point: 88%
  - Closing count before closing of wound: 100%
  - Counts audible: 100%
  - Unnecessary activity and distractions: 75%
  - Whiteboard legible: 100%
  - Staff change: 33%
  - Initial, pre-closure, and end counts completed?: 87%

METHODOLOGY
- GAP ANALYSIS REVEALED
  - Double standard identified
  - Local hospital uses whiteboards, but ambulatory surgical center does not
  - Both facilities owned by HCA
  - Surgical staff often work at both facilities
  - Incongruent surgical count process leads to mistakes

O.R. COUNT BOARD

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OUTCOMES
- No incidence of URFOs since implementation
- Whiteboards met ASC’s top safety priority of eliminating URFOs
- Standardized the surgical count process at both local HCA facilities

PRACTICE IMPLICATIONS

CONCLUSION
- Improved manual surgical count process
- Increased patient safety and improved patient outcomes
- Inclusion of all interdisciplinary team members
- Reduction of the risk of unintended retained foreign objects

RECOMMENDATION
- Complete three surgical counts using the whiteboard